DISCHARGE PLAN

PRE-DISCHARGE

Anticipated Date of Discharge: _____

Revised Anticipated Date of Discharge ***(Initial and Date each entry)***

1. _____ *Initial/Date* _____
2. _____ *Initial/Date* _____
3. _____ *Initial/Date* _____

Barriers to Discharge:

_____

_____

_____

_____

MEDICAL

Primary Care Physician: _____

❑ Lab Work *(specify type)* _____

_____

Provider _____ *Frequency* _____

❑ Other: _____

_____

Specify providers for Medical needs: ❑ N/A

1. _____ *Frequency* _____
2. _____ *Frequency* _____
3. _____ *Frequency* _____
4. _____ *Frequency* _____
5. _____ *Frequency* _____

Revisions/Updates *(Initial and Date each entry)*

❑ _____

❑

MEDICATION

Specify Provider/Frequency for each service below: ❑ N/A

❑ Self-Administration

❑ Medications packaged by pharmacy
Provider _____ *Frequency* _____

❑ Prompts/Reminders
Provider _____ *Frequency* _____

❑ Observation
Provider _____ *Frequency* _____

❑ Medication Administered
Provider _____ *Frequency* _____

❑ Assistance with Medi-Planner
Provider _____ *Frequency* _____

❑ Other Service(s): _____
Provider _____ *Frequency* _____

Revisions/Updates *(Initial and Date each entry)*

❑ _____

❑

SUBSTANCE ABUSE

Specify Provider/Frequency/Duration of each service: ❑ N/A

❑ SA Assessment: *Provider* _____
Frequency/Duration _____

❑ AA/NA Meetings: *Location* _____
Frequency/Duration _____

❑ Intensive Outpatient: *Provider* _____
Frequency/Duration _____

❑ SA Residential Treatment: *Provider* _____
Frequency/Duration _____

❑ Other Service/Provider: _____
Frequency/Duration _____

Revisions/Updates *(Initial and Date each entry)*

❑ _____

❑

PSYCHIATRIC/THERAPEUTIC

Specify Provider/Frequency for each service checked: ❑ N/A

❑ Medication Management
Provider _____ *Frequency* _____

❑ Case Management
Provider _____ *Frequency* _____

❑ Individual psychotherapy
Provider _____ *Frequency* _____

❑ Group therapy
Provider _____ *Frequency* _____

❑ Day Treatment/Partial Hospitalization
Provider _____ *Frequency* _____

❑ Couples/Family therapy
Provider _____ *Frequency* _____

❑ Other Service(s): _____

_____

_____

Revisions/Updates *(Initial and Date each entry)*

❑ _____

❑

ADDRESSOGRAPH

DISCHARGE PLAN

DAILY LIVING

Hygiene ❑ N/A

- ❑ Education/Skills Training: *Provider*_____
  Frequency/Duration _____
- ❑ Prompts/Reminders: *Provider*_____
  Frequency/Duration _____
- ❑ Periodic Monitoring/Assistance: *Provider*_____
  *Frequency/Duration*_____
- ❑ Other: _____

Transportation ❑ N/A

- ❑ Education/Skills Training: *Provider*_____
  Frequency/Duration _____
- ❑ Assistance: *Provider*_____
  *Frequency/Duration*_____
- ❑ Transported by others: *Provider*_____
  *Frequency/Duration*_____
- ❑ Other:_____

Money Management ❑ N/A

- ❑ Education/Skills Training: *Provider*_____
  Frequency/Duration _____
- ❑ Periodic Monitoring/Assistance: *Provider*_____
  *Frequency/Duration*_____
- ❑ Representative Payee: *Provider*_____
  *Frequency/Duration*_____
- ❑ Other:_____

Employment ❑ N/A

- ❑ Education/Skills Training/Vocational Rehabilitation:
  *Provider*_____
  Frequency/Duration _____
- ❑ Paid/Volunteer Employment: *Provider*_____
  Frequency/Duration _____
- ❑ Supportive Employment/ Job Coach: _____
  Frequency/Duration _____
- ❑ Other:_____

Nutrition ❑ N/A

- ❑ Education/Skills Training: *Provider*_____
  Frequency/Duration _____
- ❑ Periodic Monitoring/Assistance: *Provider*_____
  *Frequency/Duration*_____
- ❑ Meals Prepared by others *(specify):*_____
  *Frequency/Duration*_____
- ❑ Other:_____

Shopping ❑ N/A

- ❑ Education/Skills Training: *Provider*_____
  Frequency/Duration _____
- ❑ Periodic Monitoring/Assistance: *Provider*_____
  *Frequency/Duration*_____
- ❑ Provided by others: *Provider*_____
  *Frequency/Duration*_____
- ❑ Other:_____

Leisure/Socialization ❑ N/A

- ❑ Education/Skills Training: *Provider*_____
  Frequency/Duration _____
- ❑ PSR/Clubhouse: *Provider*_____
  *Frequency/Duration*_____
- ❑ Activities planned by others *(specify)*:_____
  *Frequency/Duration*_____
- ❑ Other:_____

Education ❑ N/A

- ❑ Assessment*(specify)*_____
  *Provider*_____
  Frequency/Duration _____
- ❑ Attend school/college*(specify):*_____
  Frequency/Duration _____
- ❑ Complete GED*(specify):*_____
- ❑ Other:_____

Revisions/Updates *(Initial and Date each entry)*

- ❑ _____
- ❑

LEGAL

LAR needed in Community? *(circle) Yes No*

If *Yes*, specify status: *Applied, date*_____ *Completed, date*_____ N/A

Name of LAR: _____

Relationship to individual: _____

Type of LAR *(circle type below):*

Legal Guardian Power of Attorney Advanced Directive Other

- ❑ Other:_____

Other Legal Services:

- ❑ Attorney *(specify name):* _____
- ❑ Pending Legal Issues: _____
- ❑ Parole/Probation *(specify name):* _____
- ❑ Conditional Release plan Approved by FRP, *date* _____
- ❑ Advocacy *(describe)*_____
- ❑ Other:_____

Revisions/Updates *(Initial and Date each entry)*

- ❑ _____
- ❑

ADDRESSOGRAPH

DISCHARGE PLAN

FINANCIAL

Specify status of benefits ***(applied, approved, not eligible, etc.)***

- ❑ SSI *$_____/month* Status: _____
- ❑ SSDI*$_____/month* Status: _____
- ❑ Medicaid Type/Status: _____
- ❑ Medicare: Part A&B Part A only Part B only *Status?*_____
- ❑ Family Support
- ❑ CSA funding
- ❑ Pension $_____*/month*
- ❑ Special Project *(specify)*_____
- ❑ Other:_____
- ❑ Food Stamps
- ❑ General Relief
- ❑ VA Benefits_____

Revisions/Updates *(Initial and Date each entry)*

❑ _____

❑

HOUSING

Specify Type of Housing:

- ❑ With Family/Significant Others
- ❑ Assisted Living Facility (ALF)
- ❑ Residential Treatment Program
- ❑ Crisis Care Facility
- ❑ Transfer to inpatient facility
- ❑ Independent Apartment
- ❑ Supervised Apartment
- ❑ Group Home
- ❑ Nursing Home
- ❑ Correctional Facility
- ❑ Host Home/Foster Care
- ❑ Other _____

Specify Provider/Location/Description of Service:_____

Revisions/Updates *(Initial and Date each entry)*

❑ _____

❑

SUPERVISION

Specify Purpose/Provider/Frequency/Duration of Supervision ❑ N/A

❑ Supervision for *(specify)*_____

*Provider*_____ *Frequency/Duration* _____

❑ Supervision for *(specify)*_____

*Provider*_____ *Frequency/Duration* _____

Revisions/Updates *(Initial and Date each entry)*

❑ _____

❑

TRANSITION

Transition Plan ***(list provider/frequency/duration/dates):*** ❑ N/A

_____

_____

_____

CRISIS

Crisis Plan ***(attach additional pages as needed)***_____

_____

OTHER

Describe other services to be provided below: ❑ N/A

❑ Religious _____ ❑ Cultural _____ ❑ Other:_____

Revisions/Updates *(Initial and Date each entry)*

❑ _____

❑

SIGNATURES

Completed by (CSB staff):

_____

Signature *Title* *Date*

CSB: _____

_____

Individual Receiving Services *Date*

Revisions/Updates (CSB staff):

_____

Initials/Signature *Title* *Date*

_____

Initials/Signature *Title* *Date*

_____

Legally Authorized Representative *Date*

ADDRESSOGRAPH